Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRADLEY T EDWARDS
7401 SOUTH MAIN STREET
HOUSTON TEXAS 77030

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
FIRST NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3214-01

MFDR Date Received
May 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Current Coventry contract is for 100% of the TX work comp..."

Amount in Dispute: $553.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the provider's complaint the carrier disagrees with the provider's calculation of the TX workers compensation fee schedule as the correct payment allowance for the physicians fee schedule for CPT 23472 is $2232.60 and was paid to the provider on 12/17/2010 under ICN 06810207246504, based on the provider's location billed as Houston 77030 in Harris County. A payment of $2232.60 was paid to the provider on 12/17/2010 under ICN 06810207246504. Carrier agrees that the contract was applied correctly as 100% of the TX fee schedule allowance was paid to the provider."

Response Submitted by: Coventry Workers' Comp Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2010	23472	$553.12	$553.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 97 – Payment is included in the allowance for another service/procedure
   - 1 – This contracted provider or hospital has agreed to reduce this charge below fee schedule usual and customary.
   - 2 – This bill was reviewed in accordance with your Fee for Service contract with Coventry.
   - 3 – Left side
   - 4 – Diagnosis Code indicates severe injury
   - 5 – The charge for this procedure exceeds $5,000.00
   - 6 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Did the requestor submit the dispute timely within the one year filing deadline?
2. Did the insurance carrier issue payment per the DWC Fee Guideline and is the requestor entitled to additional reimbursement?

Findings

1. Per former 28 Texas Administrative Code §133.307, "(c) (c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."
   - The disputed date of service is September 17, 2010. The Medical Fee Dispute Resolution request was received by medical fee dispute on May 23, 2011. The request was therefore made timely and eligible for review.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   Per 28 Texas Administrative Code §134.203 "(g) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services."

   - Review of the submitted documentation indicates that the requestor seeks the DWC fee guideline reimbursement. The insurance carrier also indicates that payment is issued at 100% of the TX fee schedule allowance. The insurance carrier issued payment in the amount of $2,232.60 utilizing the non-surgery DWC conversion factor of $54.32 which resulted in a fee guideline amount of $2,232.60.
   - The requestor seeks reimbursement for CPT code 2347 2 defined as "Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)."
   - The requestor billed for surgical services rendered in a facility indicated by place of service code 21 on the CMS 1500. Reimbursement is calculated at the facility rate with the DWC surgery conversion factor of $68.19. The 2010 Medicare facility reimbursement rate for CPT code 23472 is $1,515.51, calculated with the DWC surgery conversion factor for 2010 of $68.19 equals a DWC fee guideline amount of $2,802.67.
   - The insurance carrier paid the amount of $2,232.60, the requestor seeks additional reimbursement amount of $553.12. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $553.12.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $553.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.